State of Iowa
Enrollment Agreement
2006 Plan Year

I wish to have my salary redirected beginning the 1st day of the month of _____, 2006 through **DECEMBER 31, 2006** in each of the categories below. I understand the benefits available to me as well as the other rights and obligations that I have under the Plan. I understand this agreement revokes any prior election under this plan and that during the above period this agreement is irrevocable and cannot be changed except under special circumstances as outlined in the Summary Plan Description. This agreement is subject to the terms of the State of Iowa Cafeteria Plan.

Social Security Number _____/_____/_____

Name _____
(Last, First MI)
Street _____

City _____
State, Zip

	Per Pay Period	# of Pay Periods	Total for the Plan Year	Not to Exceed
Health Flexible Spending Account	_____	_____	_____	$2,500
Dependent Care Flexible Spending Account	_____	_____	_____	$5,000*

* Cannot exceed $2,500 if married & filing separately

DIRECT DEPOSIT REIMBURSEMENT

I authorize ASI to credit my_____(checking, savings) account number _____ at (name of bank) _____, with my Flexible Spending Account payments. Please attach a copy of a check or a void check and write the bank's routing number _ _ _ _ _ _ _ _ _.

E-MAIL

_____ I wish to receive my notification of direct deposit reimbursement via e-mail over the Internet at the address below.

E-mail address: _____

Employee's Signature: _____ Date _____

Return this form to your department's personnel assistant

ASI - 1-800-659-3035 email: asi@asiflex.com http://www.asiflex.com

PERSONNEL ASSISTANT USE ONLY:

Dept. 10 Digit #: _____ Hire date _____
(New hires only)

Employees must be full-time or part-time and work 1040 hours annually on a regular basis to be eligible to participate in either flexible spending account. I certify this employee meets those eligibility requirements.

Personnel Assistant Signature: _____ Date _____

Phone: _____